1.0 PURPOSE

It is the purpose of this policy to provide guidance to law enforcement officers when dealing with suspected mentally ill persons.

2.0 POLICY

It is the policy of the Department of Public Safety to provide its commissioned employees with guidelines for the recognition of persons suffering from mental illness as well as guidelines for how to deal with them most effectively.

3.0 APPLICABILITY

This policy is applicable to commissioned officers of the Department of Public Safety.

4.0 REFERENCES

A. 43-1-10 Emergency Mental Health Evaluation and Care, NMSA 1978

B. 32A-6-11 Emergency Mental Health Evaluation and Care, NMSA 1978

C. CALEA Chapter 41 – Patrol

5.0 DEFINITIONS

A. Mental Illness: A medical condition that disrupts a person's thinking, feeling, mood, ability to relate to others and daily functioning that often results in a diminished capacity for coping with the ordinary demands of life. Mental illnesses can affect persons of any age, race, religion or income. A subject may suffer from mental illness if he/she displays an inability to think rationally, exercise adequate control over behavior or impulses (e.g., aggressive, suicidal, homicidal, sexual), and/or take reasonable care of his/her welfare with regard to basic provisions for clothing, food, shelter, or safety.

6.0 PROCEDURE

A. RECOGNIZING PERSONS SUFFERING FROM MENTAL ILLNESS

1. Officers are not expected to act as mental health clinicians, make diagnoses, or provide medical or psychiatric advice, but they should be aware of commonly encountered behaviors associated with mental disorders. Officers should not rule out other potential causes, such as reactions to narcotics, alcohol or temporary emotional disturbances that are situationally motivated.

   Mental illnesses and related disorders commonly encountered by law enforcement include, but are not limited to, the following:

   a. Thought disorders (psychosis, schizophrenia);

b. Mood disorders (bi-polar disorder, depression);

c. Anxiety disorders (panic disorders, phobias, obsessive-compulsive disorder, post-traumatic stress disorder a.k.a. PTSD);

d. Substance abuse disorders (alcoholism, drug addiction, delirium tremens or DT's, withdrawal symptoms);

e. Elder disorders (delirium, dementia, Alzheimer's disease);

f. Developmental disabilities (Down's syndrome, autism spectrum disorders); or

g. Medical conditions with behavioral symptoms (over 300 medical conditions, including cerebral palsy, diabetic emergencies, medication toxicity, etc.).

2. Recognition and Clues of Mental Disorders – Below are three types of indicators that a person may be suffering from mental illness:

a. Verbal Clues

i. Illogical thoughts

1. Expressing a combination of unrelated or abstract topics

2. Expressing thoughts of greatness, e.g., person believes he is God

3. Expressing ideas of being harassed or threatened, .e.g, CIA monitoring thoughts through a TV set

4. Preoccupation with death, germs, guilt, etc

ii. Unusual Speech Patterns

1. Nonsensical speech or chatter

2. Word repetition-frequently stating the same or rhyming words or phrases

3. Pressured speech-expressing urgency in manner of speaking

4. Extremely slow speech

iii. Verbal Hostility or excitement

1. Talking excitedly or loudly

2. Argumentative, belligerent, unreasonably hostile

3. Threatening to harm self or others

4. Distrust of others

b. Behavioral Clues

i. Physical appearance

1. Inappropriate to environment – e.g., shorts in winter, heavy coat in summer

2. Bizarre clothing or make up taking into account current trends – e.g. tin foil hats, earphones, etc.

ii. Body movements

1. Strange postures or mannerisms
2. Lethargic, sluggish movements
3. Repetitious, ritualistic movements – e.g. twirling of hair, walking in circles, flapping of hand etc
4. Extreme rigidity or inflexibility
5. Lack of facial expressions

iii. Seeing or hearing things that aren't able to be confirmed – e.g. one-sided conversations, hearing voices, imagined being/animals, hallucinations, etc.

iv. Loss of memory/disorientation – Significant memory loss, such as name, day, year, or familiar people such as family and loved ones

v. Confusion about or unawareness of surroundings

vi. Lack of emotional response

vii. Causing injury to self

viii. Nonverbal expressions of sadness or grief

ix. Disordered thinking and speech

x. Despondent – Depressed, angry, guilty, suicidal

xi. Mania – Racing thoughts, compressed speech, hyperactivity, irritability, euphoria, decreased need for sleep

xii. Inappropriate emotional reactions

1. Overreacting to situations in an overly angry or frightening way
2. Reacting with the opposite of expected emotions – e.g., laughing at an automobile accident.
3. Easily frustrated in new or unforeseen circumstances
4. Intense feeling of fear or dread
5. Despondent – Depressed, angry, guilty, suicidal

c. Environmental Cues – Surroundings are inappropriate, such as:

i. Decorations

Strange trimmings, inappropriate use of household items, e.g., aluminum foil covering windows

ii. Waste matter/trash

1. "Pack ratting" – accumulation of trash, e.g., hording string, newspapers, paper bags, clutter, etc.
2. Presence of feces or urine on the floor or walls

iii. Childish objects

3. When making observations, personnel should note as many cues as possible, put the cues into the context of the situation and be mindful of environmental and cultural factors.

4. Officers are expected to familiarize themselves with local mental health organizations, as well as the types of services available in their areas of responsibility.

B. DETERMINING LEVEL OF PERCEIVED DANGER

1. Officers may use several indicators to determine whether an apparently mentally ill person represents an immediate or potential danger to him/herself, the officer, or others. The following factors alone may not determine a level of danger, but may assist an officer in making a proper assessment:

   a. The availability of any weapons to the person;

   b. Statements by the person that suggest to the officer that the individual is prepared to commit a violent or dangerous act;

   c. A personal history that reflects prior violence under similar or related circumstances. The person's history may be known to the officer, or family, friends or neighbors may be able to provide such information; or

   d. The amount of control the person demonstrates is significant, particularly the amount of physical control over emotions of rage, anger, fright or agitation. Signs of a lack of control include extreme agitation, inability to sit still or communicate effectively, wide eyes, and rambling thoughts and speech. Clutching one's self or other objects to maintain control, begging to be left alone, or offering frantic assurances that one is all right may also suggest that the individual is close to losing control.

C. LAW ENFORCMENT RESPONSE

1. A mentally ill person in a crisis situation is generally scared. Should the officer determine that an individual may be mentally ill and a potential threat to self, the officer or others, he/she may require law enforcement intervention for humanitarian reasons, as prescribed by statute. The following guidelines should be followed:

   a. When interacting with a mentally ill person personnel should:

      i. Continually assess the situation for danger;

      ii. Maintain adequate space between the officer and subject;

      iii. Remain calm;

      iv. Give firm, clear directions;

      v. Have only one officer talk to the subject, if possible;

      vi. Respond to apparent feelings, rather than content;

      vii. Respond to delusions and hallucinations by talking about the person's feelings rather than what he/she is saying; and/or

viii. Be helpful, or offer assistance to make the person feel safer/calmer, etc.

b. When interacting with a mentally ill person, personnel should not:

i. Join into the behavior related to the person's mental illness, e.g., agreeing/disagreeing with delusions or hallucinations;

ii. Stare at the subject (this action may be interpreted as a threat);

iii. Confuse the subject (one officer should interact with the subject);

iv. Give multiple choices (giving multiple choices increases the subject's confusion);

v. Whisper, laugh or joke (this will increase the subject's suspiciousness increasing the potential for violence);

vi. Deceive the subject (being dishonest increases fear and suspicion); and/or

vii. Engage in any unnecessary contact (although touching can be helpful to some people who are upset, for the disturbed mentally ill person, it may cause more fear in the person and lead to violence).

2. Officers shall use the utmost care and exercise a heightened level of officer safety when interviewing or interrogating individuals who are suspected of suffering from mental illness. When possible, officers should have a second officer present and a recording of the interview shall be made.

D. TAKING INTO CUSTODY OR MAKING REFERRALS

1. Based on the overall circumstances and the officer's judgment of the potential for violence, the officer may provide the individual and family members with referrals to available community mental health resources or take custody of the individual in order to seek an involuntary emergency evaluation.

2. The officer may make mental health referrals when, in the best judgment of the officer, the circumstances do not indicate that the individual must be taken into custody for his own protection or the protection of others, or for other reasons as specified by state law.

3. Once a decision has been made to arrest or take an individual into custody, it should be done as soon as possible to avoid prolonging a potentially volatile situation. If released to a detention facility, the officer should advise personnel of any abnormal statements made by the individual and document those statements on the booking sheet. Officers may take a subject into custody without a court order according to §*43-1-10, NMSA 1978, Emergency Mental Health Evaluations and Care,* under the following circumstances:

a. The individual is otherwise subject to lawful arrest;

b. The officer has reason to believe the individual has just attempted suicide;

c. The officer, based on observations and investigation, has reasonable grounds to believe the person, as a result of mental disorder, presents a likelihood of serious harm to self or others and that immediate detention is required to prevent such harm; or

d. A licensed physician or a certified psychologist has certified that the person, as a result of a mental disorder, presents a likelihood of serious harm to self or others and that immediate detention is necessary to prevent such harm.

4. A child may be detained for an emergency mental health evaluation and care without a court order according to *§32A-6-11, NMSA 1978, Emergency Mental Health Evaluation and Care,* under the following circumstances:

   a. The officer has reasonable grounds to believe the child has just attempted suicide;

   b. The officer, based on observations and investigation, has reasonable grounds to believe the child, as a result of mental disorder, presents a likelihood of serious harm to self or others and that immediate detention is required to prevent such harm;

   c. The officer has certification from a clinician that the child, as a result of a mental disorder, presents the likelihood of serious harm to self or others and that immediate detention is necessary to prevent such harm; or

   d. The peace officer has an involuntary placement order issued by a tribal court that orders the child to be admitted to an evaluation facility.

   e. Officers shall immediately transport any child detained under this law to an evaluation facility. No child shall be held, for purposes of a mental health evaluation or care, in a jail or other facility intended for the incarceration of adults charged with criminal charges or for the detention of children adjudicated to be delinquent children.

E. DEPARTMENTAL TRAINING

1. Commissioned officers and/or recruits shall be provided documented, entry-level academy training on recognizing and responding to individuals suspected of suffering from mental illness.

2. Commissioned officers shall be provided documented refresher training on this subject at least every three (3) years.

7.0 ATTACHMENTS

NONE

8.0 APPROVAL

APPROVED BY: s/ Gregory J. Fouratt DATE: December 30, 2014
DPS Cabinet Secretary